		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040311

Facility Name: PRAIRIE VIEW CARE CENTER-CHARLESTON

Address: 716 EIGHTEENTH STREET (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-1304215

Date of Initial License for Current Owners: 2/1/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD., 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	45	Skilled (SNF)	45	16,425	1
2		Skilled Pediatric (SNF/PED)			2
3	94	Intermediate (ICF)	94	34,310	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,271	2,271	8
9	SNF/PED					9
10	ICF	23,508	10,168	373	34,049	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,508	10,168	2,644	36,320	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.59%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,271

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLES # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	132,397	8,150	6,688	147,235		147,235	0	147,235			1
2	Food Purchase		172,479		172,479		172,479	(5,606)	166,873			2
3	Housekeeping	62,717	27,234	0	89,951		89,951	390	90,341			3
4	Laundry	38,329	15,227	461	54,017		54,017	0	54,017			4
5	Heat and Other Utilities			120,133	120,133		120,133	629	120,762			5
6	Maintenance	47,778	21,691	15,448	84,917		84,917	646	85,563			6
7	Other (specify):* scavenger			6,931	6,931		6,931	0	6,931			7
8	**TOTAL General Services**	281,221	244,781	149,661	675,663	0	675,663	(3,941)	671,722			8
	B. Health Care and Programs											
9	Medical Director	0		6,500	6,500		6,500	0	6,500			9
10	Nursing and Medical Records	1,191,270	109,866	15,281	1,316,417		1,316,417	16,721	1,333,138			10
10a	Therapy	8,275	1,313	12,291	21,879		21,879	(63,290)	(41,411)			10a
11	Activities	58,677		2,005	60,682		60,682	0	60,682			11
12	Social Services	22,179		3,501	25,680		25,680	0	25,680			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,280,401	111,179	39,578	1,431,158	0	1,431,158	(46,569)	1,384,589			16
	C. General Administration											
17	Administrative	37,967		28,000	65,967		65,967	15,704	81,671			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			39,732	39,732		39,732	9,375	49,107			19
20	Dues, Fees, Subscriptions & Promotions			23,436	23,436		23,436	(8,014)	15,422			20
21	Clerical & General Office Expenses	75,564	22,566	143,426	241,556		241,556	(15,370)	226,186			21
22	Employee Benefits & Payroll Taxes			267,864	267,864		267,864	23,283	291,147			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			2,158	2,158		2,158	8,445	10,603			24
25	Other Admin. Staff Transportation			9,457	9,457		9,457	9,664	19,121			25
26	Insurance-Prop.Liab.Malpractice			65,488	65,488		65,488	4,361	69,849			26
27	Other (specify):*			0	0		0	0	0			27
28	**TOTAL General Administration**	113,531	22,566	579,561	715,658	0	715,658	47,448	763,106			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,675,153	378,526	768,800	2,822,479	0	2,822,479	(3,062)	2,819,417			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON #0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,051	36,051		36,051	158,033	194,084			30
31	Amortization of Pre-Op. & Org.				0		0	3,252	3,252			31
32	Interest			14,213	14,213		14,213	445,546	459,759			32
33	Real Estate Taxes			64,315	64,315		64,315	0	64,315			33
34	Rent-Facility & Grounds			587,462	587,462		587,462	(582,092)	5,370			34
35	Rent-Equipment & Vehicles			2,558	2,558		2,558	0	2,558			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			704,599	704,599	0	704,599	24,739	729,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			54,167	54,167		54,167	51,491	105,658			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			76,103	76,103		76,103	0	76,103			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	130,270	130,270	0	130,270	51,491	181,761			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,675,153	378,526	1,603,669	3,657,348	0	3,657,348	73,168	3,730,516			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,287)	30		9
10	Interest and Other Investment Income	(57)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,935)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(671)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(539)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(8,416)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	0	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,905)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	120,073		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 120,073		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 73,168		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PRAIRIE VIEW CARE CENTER-CHARLESTON

ID# 0040311

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,606)	0	0	0	0	0	0	0	0	0	0	(5,606)	2
3	Housekeeping	0	0	390	0	0	0	0	0	0	0	0	390	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	629	0	0	0	0	0	0	0	0	629	5
6	Maintenance	0	0	646	0	0	0	0	0	0	0	0	646	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,606)	0	1,665	0	0	0	0	0	0	0	0	(3,941)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,721	0	0	0	0	0	0	0	0	16,721	10
10a	Therapy	0	(63,290)	0	0	0	0	0	0	0	0	0	(63,290)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(63,290)	16,721	0	0	0	0	0	0	0	0	(46,569)	16
	C. General Administration													
17	Administrative	0	(28,000)	43,704	0	0	0	0	0	0	0	0	15,704	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	9,158	217	0	0	0	0	0	0	0	9,375	19
20	Fees, Subscriptions & Promotions	(8,416)	0	402	0	0	0	0	0	0	0	0	(8,014)	20
21	Clerical & General Office Expenses	(539)	(110,445)	93,822	1,792	0	0	0	0	0	0	0	(15,370)	21
22	Employee Benefits & Payroll Taxes	0	0	18,432	4,851	0	0	0	0	0	0	0	23,283	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,692	753	0	0	0	0	0	0	0	8,445	24
25	Other Admin. Staff Transportation	0	0	7,888	1,776	0	0	0	0	0	0	0	9,664	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,361	0	0	0	0	0	0	0	0	4,361	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,955)	(138,445)	185,459	9,389	0	0	0	0	0	0	0	47,448	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,561)	(201,735)	203,845	9,389	0	0	0	0	0	0	0	(3,062)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(32,287)	187,521	2,799	0	0	0	0	0	0	0	0	158,033	30
31	Amortization of Pre-Op. & Org.	0	3,252	0	0	0	0	0	0	0	0	0	3,252	31
32	Interest	(57)	445,532	71	0	0	0	0	0	0	0	0	445,546	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(587,462)	5,370	0	0	0	0	0	0	0	0	(582,092)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(32,344)	48,843	8,240	0	0	0	0	0	0	0	0	24,739	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	51,491	0	0	0	0	0	0	0	51,491	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	51,491	0	0	0	0	0	0	0	51,491	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,905)	(152,892)	212,085	60,880	0	0	0	0	0	0	0	73,168	45

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 28,000	CERTIFIED HEALTH MANAGEMENT		$	$ (28,000)	1
2	V	21	BOOKKEEPING FEES	115,500	CERTIFIED HEALTH MANAGEMENT			(115,500)	2
3	V	10a	THERAPY	63,290	CHM THERAPY			(63,290)	3
4	V								4
5	V	34	RENT	587,462	PRAIRIE VIEW CARE CENTER OF CHARLESTON LLC			(587,462)	5
6	V								6
7	V	21	OFFICE EXPENSE		" " " " " "		5,055	5,055	7
8	V	30	DEPRECIATION		" " " " " "		187,521	187,521	8
9	V	31	AMORTIZATION		" " " " " "		3,252	3,252	9
10	V	32	INTEREST		" " " " " "		445,532	445,532	10
11	V								11
12	V								12
13	V								13
14	Total			$ 794,252			$ 641,360	$ * (152,892)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$			$ 390	$ 390	15
16	V	5	ELECTRICITY & GAS				629	629	16
17	V	6	MAINTENANCE				646	646	17
18	V	10	NURSING/MEDICAL RECORDS				16,721	16,721	18
19	V	17	ADMIN SALARIES				43,704	43,704	19
20	V	19	PROFESSIONAL FEES				9,158	9,158	20
21	V	20	FEES, SUBSCRIPTIONS				402	402	21
22	V	21	OFFICE EXPENSE				93,822	93,822	22
23	V	22	EMPLOYEE BENEFITS				18,432	18,432	23
24	V	24	TRAVEL/SEMINAR				7,692	7,692	24
25	V	25	TRANSPORTATION				7,888	7,888	25
26	V	26	INSURANCE				4,361	4,361	26
27	V	30	DEPRECIATION				2,799	2,799	27
28	V	32	INTEREST				71	71	28
29	V	34	OFFICE RENT				5,370	5,370	29
30	V	35	EQUIPMENT RENT						30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 212,085	$ * 212,085	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$			$ 51,491	$ 51,491	15
16	V	19	PROFESSIONAL FEE				217	217	16
17	V	21	OFFICE EPXNESE				1,792	1,792	17
18	V	22	EMPLOYEE BENEFITS				4,851	4,851	18
19	V	24	TRAVEL/SEMINARS				753	753	19
20	V	25	TRANSPORTATION				1,776	1,776	20
21	V	35	EQUIPMENT RENT				0		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 60,880	$ * 60,880	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARL # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE						$ 11,775	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE						4,725	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	36,356	$ 390	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		36,356	629	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		36,356	646	3
4	10	NURSING/MEDICAL RECORD	" " "	279,537	8	128,566	128,566	36,356	16,721	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	36,356	43,704	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		36,356	9,158	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		36,356	402	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	36,356	93,822	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		36,356	18,432	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		36,356	7,692	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		36,356	7,888	11
12	26	INSURANCE	" " "	279,537	8	33,528		36,356	4,361	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		36,356	2,799	13
14	32	INTEREST	" " "	279,537	8	549		36,356	71	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		36,356	5,370	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 212,085	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CHM THERAPY
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	USAGE	100	5	$ 271,007	$ 271,007	19	$ 51,491	1
2	19	PROFESSIONAL FEE	USAGE	100	5	1,143		19	217	2
3	21	OFFICE EPXNESE	USAGE	100	5	9,430		19	1,792	3
4	22	EMPLOYEE BENEFITS	USAGE	100	5	25,530		19	4,851	4
5	24	TRAVEL/SEMINARS	USAGE	100	5	3,963		19	753	5
6	25	TRANSPORTATION	USAGE	100	5	9,348		19	1,776	6
7	35	EQUIPMENT RENT	USAGE	100	5				0	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,421	$ 271,007		$ 60,880	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLE# 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$10,613.00	4/00	$ 512,915	$ 396,899	9/02	10.5000	$ 34,430	1
2	GERSHON BASSMAN	X		MORTGAGE	$12,176.00	4/00	1,282,288	1,242,234	3/20	9.7500	122,290	2
3	CIB BANK		X	MORTGAGE	$28,608.00	4/00	2,974,908	2,894,568	3/20	9.7500	288,812	3
4												4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				48,907		PRIME+	12,735	6
7	AICC		X	INS FINANCE							1,478	7
8												8
9	TOTAL Facility Related				$51,397.00		$ 4,770,111	$ 4,582,608			$ 459,745	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 4,770,111	$ 4,582,608			$ 459,745	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 63,240	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 63,146	2
3. Under or (over) accrual (line 2 minus line 1).		$ (94)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 64,409	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 64,315	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	63,793	8
	1997	69,093	9
	1998	63,100	10
	1999	62,000	11
	2000	63,146	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VIEW CARE CENTER-CHARLESTON COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0040311

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-2-13403-000		$ 63,146.16	$ 63,146.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,146.16	$ 63,146.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 208,500	1
2					2
3	TOTALS			$ 208,500	3

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$ 3,753,000	$ 136,473	27.5	$ 136,473	$	$ 233,150	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	10,990	316	30	316		2,945	9
10	LEASEHOLD IMPROVEMENTS			1994	18,622	477	39	477		3,454	10
11	CUBICLE CURTAIN,TILE,LIGHTS			1995	10,267	326	39	326		1,969	11
12	BATH/SHOWER REPAIR			1995	12,843	408	39	408		2,596	12
13	ROOF REPAIR			1995	2,005	64	39	64		382	13
14	WATER HEATER			1995	4,791	152	39	152		909	14
15	ALARM SYSTEM			1996	712	18	39	18		101	15
16	CARPET,TILE,BASE			1996	7,800	200	39	200		1,037	16
17	PARKING LOT REPAVING			1996	13,485	899	39	899		4,944	17
18	ARCHIETCT			1996	830	21	39	21		113	18
19	FRONT ENTRANCE REMODELING			1997	80,830	2,389	39	2,389		10,864	19
20	FRONT ENTRANCE SIDEWALK/LANDSCAPING			1997	12,255	500	15	500		2,408	20
21	FLOOR TILES			1998	10,365	266	39	266		1,053	21
22	ELECTRICAL WORK			1998	5,137	132	39	132		459	22
23	WINDOWS			1998	1,852	47	39	47		167	23
24	ELECTRICAL WORK			1999	1,482	38	39	38		112	24
25	ROOFTOP AC			1999	6,900	177	39	177		450	25
26	AIR CONDITIONERS			2000	11,702	2,866	20	585	(2,281)	878	26
27	WATER HEATER			2000	3,378	123	27.5	123		128	27
28	FLOOR TILES			2001	2,365	25	27.5	43	18	43	28
29	HANDRAILS/BUMPER GUARDS			2001	13,965	64	27.5	254	190	254	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,985,576	$ 145,981		$ 143,908	$ (2,073)	$ 268,416	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 180,485	$ 18,902	$ 18,451	$ (451)	8-10 YRS	$ 87,594	71
72	Current Year Purchases	19,376	2,438	969	(1,469)	10 YRS	969	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	261,916	53,847	26,192	(27,655)	10 YRS		74
75	TOTALS	$ 461,777	$ 75,187	$ 45,612	$ (29,575)		$ 88,563	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT,NURSING,ACTV	1997 FORD VAN	1999	$ 22,821	$ 5,203	$ 4,564	$ (639)	5 YRS	$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 22,821	$ 5,203	$ 4,564	$ (639)		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,678,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,371	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,084	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (32,287)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 356,979	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,558 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 47,832	$		$ 47,832	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			94			94	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,241			6,241	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 54,167	$		$ 54,167	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,200)	599,655		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,671		6
7	Other Prepaid Expenses	11,483		7
8	Accounts Receivable (owners or related parties)	23,571		8
9	Other(specify): R/E ESCROW	17,222		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 725,602	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	232,576		15
16	Equipment, at Historical Cost	222,682		16
17	Accumulated Depreciation (book methods)	(200,803)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 254,455	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 980,057	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 386,387	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,500		28
29	Short-Term Notes Payable	48,907		29
30	Accrued Salaries Payable	67,182		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,132		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,409		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 581,517	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	190,360		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 190,360	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 771,877	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 208,180	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 980,057	$ 0	48

***(See instructions.)**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 136,229	1
2	Restatements (describe):		2
3	**W/O DUE TO/FROM MEDICARE**	31,413	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 167,642	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	40,538	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 40,538	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 208,180	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,662,837	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,662,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	30,114	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,114	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	4,935	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,935	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,697,886	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	675,663	31
32	Health Care	1,431,158	32
33	General Administration	715,658	33
	B. Capital Expense		
34	Ownership	704,599	34
	C. Ancillary Expense		
35	Special Cost Centers	54,167	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,657,348	40
41	**Income before Income Taxes (line 30 minus line 40)****	40,538	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 40,538	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,096	$ 46,083	$ 21.99	1
2	Assistant Director of Nursing	1,968	2,080	38,531	18.52	2
3	Registered Nurses	8,271	9,036	157,853	17.47	3
4	Licensed Practical Nurses	13,544	19,079	263,535	13.81	4
5	Nurse Aides & Orderlies	57,944	61,967	626,077	10.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	413	469	8,275	17.64	8
9	Activity Director	1,932	1,976	20,525	10.39	9
10	Activity Assistants	4,802	5,214	38,152	7.32	10
11	Social Service Workers	1,904	2,068	22,179	10.72	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	19,279	9.27	13
14	Head Cook	5,489	5,832	44,156	7.57	14
15	Cook Helpers/Assistants	9,851	10,402	68,962	6.63	15
16	Dishwashers					16
17	Maintenance Workers	3,412	3,665	47,778	13.04	17
18	Housekeepers	9,919	10,422	62,717	6.02	18
19	Laundry	5,871	6,132	38,329	6.25	19
20	Administrator	1,968	2,080	37,967	18.25	20
21	Assistant Administrator					21
22	Other Administrative	1,984	2,080	34,844	16.75	22
23	Office Manager	1,687	1,710	26,570	15.54	23
24	Clerical	1,580	1,636	14,150	8.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,944	2,110	17,107	8.11	31
32	Other Health C: CARE PLAN COO	2,008	2,160	35,181	16.29	32
33	Other(specify) TRANSPORT AII	1,156	1,186	6,903	5.82	33
34	TOTAL (lines 1 - 33)	141,583	155,480	$ 1,675,153 *	$ 10.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,531	1-3	35
36	Medical Director		6,500	9-3	36
37	Medical Records Consultant		735	10-3	37
38	Nurse Consultant		3,740	10-3	38
39	Pharmacist Consultant		1,362	10-3	39
40	Physical Therapy Consultant		2,463	10a-3	40
41	Occupational Therapy Consultant		4,269	10a-3	41
42	Respiratory Therapy Consultant		3,367	10a-3	42
43	Speech Therapy Consultant		2,192	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		3,501	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,660		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	NONE	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGIA RYAN	ADMIN	0	$ 37,967
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 37,967

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 28,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 28,000

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK,BOKOR,KAGDA	ACCTG SVCS	$ 10,450
R.PEELO & ASSOC	ACCTG SVCS	3,750
CERTIFIED HEALTH	ADMIN CONSULT	16,421
MILLENIUM/PAYMASTER	DATA PROCESSING	4,994
ROSENTHAL&SCHANFIELD	LEGAL	615
SCHWARTZ&FREEMAN	LEGAL	344
WINSTON&STRAWN	LEGAL	268
M.BEST&FRIEDRICH	LEGAL	743
KOVITZ SHIFRIN	LEGAL	383
PERSONNEL PLANNERS	HR CONSULT	1,140
ECONOCARE	ADMIN CONSULT	624
RELATED PARTY		9,375
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 49,107

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,850
Unemployment Compensation Insurance	17,432
FICA Taxes	128,699
Employee Health Insurance	75,004
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	(121)
RELATED PARTY	23,283
TOTAL (agree to Schedule V, line 22, col.8)	$ 291,147

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,826
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,416
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	0
DUES & SUBSCRIPTIONS	7,356
LICENSES & PERMITS	1,838
RELATED PARTY	402
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,416)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,422

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,158
RELATED PARTY	8,445
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,603

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1996	$ 24,585	3	$ 8,195	$ 4,097	$	$	$	$	$	$	$
2	PAINT/DECORATING	1997	11,573	3	3,858	3,858	1,928						
3	PAINT/DECORATING	1998	7,173	3	1,196	2,392	2,392	1,196					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 43,331		$ 13,249	$ 10,347	$ 4,320	$ 1,196	$	$	$	$	$

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL COUNCIL LTC $6,260

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 76,103
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: PRAIRIE VIEW CARE CENTER-CHARLESTON #0040311 **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,531	
	REPAIRS & MAINTENANCE		157	
				6,688
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		461	
			0	461
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		2,975	
	ELECTRICITY		82,693	
	WATER		34,465	
	CABLE TV - LOBBY		0	
			0	120,133
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,942	
	PAINTING & DECORATING		116	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,261	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,129	
	FIRE SERVICE		0	
			0	
			0	15,448
7	**OTHER**			
	SCAVENGER		6,931	
	SECURITY SERVICE		0	6,931
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,500	6,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,852	
	PURCHASED SERVICES		5,592	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	735	
	PHARMACY CONSULTANT	XVIII B 39-2	1,362	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	3,740	
			0	
			0	15,281
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,463	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,269	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	3,367	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,192	12,291
11	**ACTIVITIES**			
	ACTIVITY PROGRAM EXP		2,005	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	2,005
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,501	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,501
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON **#0040311** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	28,000	28,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,994	
	ADMINISTRATIVE CONSULTANTS	XIX C	16,421	
	PROFESSIONAL FEES	XIX C	18,317	
			0	39,732
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,416	
	EMPLOYEE WANT ADS	XIX F	5,826	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,356	
	LICENSES & PERMITS	XIX F	1,838	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,436
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		661	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		115,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	539	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		2,924	
	TELEPHONE		21,422	
	MESSENGER SERVICE		0	
	POSTAGE		2,380	143,426

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	128,699	
	UNEMPLOYMENT COMPENSATION	XIX D	17,432	
	WORKERS COMPENSATION INSURANC	XIX D	46,850	
	HOSPITALIZATION INSURANCE	XIX D	75,004	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	(121)	267,864
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,158	
	TRAVEL	XIX G	0	
			0	
			0	2,158
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,457	9,457
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		65,488	65,488
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 768,800

PRAIRIE VIEW CARE CENTER-CHARLESTON
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	172,479
LESS SALES TAX	(671)
NET FOOD	173150
TOTAL PATIENT CENSUS	36,320
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	108960
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	108960
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	108960
NET FOOD	173150
DIVIDE TOTAL MEALS/YEAR	108960
COST PER MEAL	1.59
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

PRAIRIE VIEW CARE CENTER-CHARLESTON
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									3,638,784	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,431,158	267,864	301,932	54,017	319,714	447,794	76,103	704,599		1,675,153
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			0		0		
CABLE TV			0			0				
CONTRACT NURSING										
INTEREST INCOME							0			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(28,000)		28,000		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	0	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,431,158	267,864	301,932	54,017	319,714	419,794	76,103	732,599	3,603,181	1,675,153
PER FINANCIAL STATEMENTS	0	0	0	0	0	0	0	0	35,603	0
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									0	

PRAIRIE VIEW CARE CENTER-CHARLESTON - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		50,735			0			50,735	0		
CENSUS DAYS		36,320			0			36,320	0		
OCCUPANCY %		71.59%			#DIV/0!				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	281,221	7.54%	7.74				281,221			
Social Services	12-1	22,179	0.59%	0.61				22,179			
TOTAL Health Care and Programs	16-1	########	34.32%	35.25				########			
Clerical & General Office Expenses	21-1	75,564	2.03%	2.08				75,564			
TOTAL General Administration	28-1	113,531	3.04%	3.13				113,531			
TOTAL Operation Expense	29-1	########	44.90%	46.12				########			
ADJUSTED TOTALS											
Food	2-8	166,873	4.47%	4.59				166,873			
Heat and Other Utilities	5-8	120,762	3.24%	3.32				120,762			
Maintenance	6-8	85,563	2.29%	2.36				85,563			
TOTAL General Services	8-8	671,722	18.01%	18.49				671,722			
Administrative	17-8	81,671	2.19%	2.25				81,671			
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	49,107	1.32%	1.35				49,107			
Fees, Subscriptions, Promotions	20-8	15,422	0.41%	0.42				15,422			
License Fee-IDPA	Pg21	0	0.00%	0.00				0			
License Fee-Other	Pg21	1,838	0.05%	0.05				1,838			
Clerical & General Office Expenses	21-8	226,186	6.06%	6.23				226,186			
Employee Benefits & Payroll Taxes	22-8	291,147	7.80%	8.02				291,147			
Payroll Taxes	Pg21	146,131	3.92%	4.02				146,131			
W/C Insurance	Pg21	46,850	1.26%	1.29				46,850			
Health Insurance	Pg21	75,004	2.01%	2.07				75,004			
Inservice Training & Education	23-8	0	0.00%	0.00				0			
Travel and Seminar	24-8	10,603	0.28%	0.29				10,603			
Other Admin. Staff Transportation	25-8	19,121	0.51%	0.53				19,121			
Insurance-Prop.Liab.Malpractice	26-8	69,849	1.87%	1.92				69,849			
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	763,106	20.46%	21.01				763,106			
TOTAL Operation Expense	29-8	########	75.58%	77.63				########			
Real Estate Taxes	33-3	64,315	1.72%	1.77				64,315			
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	########	100.00%	**102.71**				########			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1212290	32.50%	**33.38**	#DIV/0!	#DIV/0!	**#DIV/0!**	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**

PRAIRIE VIEW CARE CENTER-CHARLESTON - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

CAUTION: Deferred maint. adj. on Page 5A Line1 has been manually adjusted.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-445532

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-190320

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

#VALUE!

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 DOES NOT EQUAL Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.